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Public Hospital District No. 3,
Grant County, Washington

Columbia Basin Hospital
Columbia Basin Family Medicine
Garden Oasis Assisted Living

POLICY AND PROCEDURE

NUMBER: 853000-006	REVIEWED AND REVISED: 02-11-2008	EFFECTIVE DATE: 02-11-08	SUPERSEDES NO./DATE: 03-20-07
DISTRIBUTION: PATIENT ACCNTG,ADMITTING, SOC SERV, EMER,CLINIC,ACCTNG AND ADMINISTRATION			
SUBJECT: FINANCIAL ASSISTANCE/ CHARITY CARE POLICY		APPROVED BY: Diane Clark DEPARTMENT DIRECTOR Darrell Jones ADMINISTRATION	

POLICY:

Columbia Basin Hospital is an open-door hospital by virtue of its being a non-profit public Hospital District hospital. The Hospital is the community's only hospital and recognizes its obligation under the Community Service Act. Services in this facility are available to all persons without discrimination on the basis of race, color, national origin, creed, or any other grounds unrelated to an individual's need for the service. Emergency services will not be denied because the person is unable to pay for those services. Persons receiving emergency services will, however, be billed for such services.

In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care are established, consistent with the requirements of the Washington Administrative Code, Chapter 246-453 and RCW 70.170. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance through the charity care program while ensuring the maintenance of a sound financial base.

Patients of Columbia Basin Hospital receiving Acute Care or outpatient services who feel they are unable to pay for those services may request financial assistance.

PROCEDURE:

Any patient, family member, or responsible party who feels they may qualify for financial assistance through charity care, may ask for a charity application at the Business Office. This application should be completed as soon as possible of the date of treatment. Hospital District personnel may suggest or offer charity applications if they feel that the patient would meet criteria for the financial assistance program or refer the patient to the Business Office for further information on the program.

ELIGIBILITY:

Applications for financial assistance are evaluated according to the following criteria:

1. Qualification under Federal poverty guidelines that are published and updated annually. The poverty income figures in effect for the time period that the services were received will be the guideline used in making a determination of eligibility.
2. Income will include all related members of the household whether through birth, marriage, or adoption, regardless of age. Combined gross income cannot exceed 300% of the poverty guideline for uninsured persons and 200% for insured persons. (See poverty guideline attachment for most current income levels.)
   A. Eligible persons with income below 100% of the poverty income guidelines will have their balance written off with no obligation to pay.
   B. Persons with income from 101 – 200% of the poverty guidelines will have their balance reduced per the attached Reduced Payment Schedule.
   C. Uninsured persons with income between 201 – 300% of the poverty guidelines will be eligible for a reduction of charges to reduce their balance due to 130% of the estimated cost to charge ratio currently in effect for the Hospital.
   D. Insured persons will be eligible for financial assistance when their income does not exceed 200% of poverty level and their balances will be reduced as listed in A and B above.
3. Review criteria for catastrophic consideration of financial assistance through the charity care program may be considered as follows:
   A. Columbia Basin Hospital charges for the patient stay total 25% of the family gross income for the year.
   B. Total medical obligations exceed 50% of the family gross income.
   C. Columbia Basin Hospital obligations exceed 40% of family liquid assets;
   D. Total medical obligations exceed 75% of liquid assets.
   E. If the change in financial status of the applicant is temporary, the hospital may choose to suspend payments temporarily rather than initiate charity care.

The charity application will include an income disclosure section with a request for documentation to be attached to verify the data reported. The following documents will be accepted as proof of income upon which to base eligibility: W-2 withholding statement, pay stubs from all employment, income tax return from the most recently filed calendar year, Medicaid approvals or denials, unemployment compensation notices, or written statements from employers. Determination is based on one full year's income from the time period that services were rendered.

If the applicant's income is below 100% of the poverty level it is not necessary to fill out the optional financial disclosure section of the application. The financial disclosure section of the application requests assets and liability information. This section is required if the patient does not meet the 100% poverty guideline and wishes to be considered for a reduction in the cost of their services based on a sliding fee scale or other catastrophic considerations for reduction.

The hospital will not initiate collection efforts on an account once a request for financial assistance is received pending the initial determination of eligibility, providing the responsible party is cooperative with the Hospital's efforts to reach a final determination and supplies the information necessary in order to make that determination.

The applicant's financial obligation which remains after charity care is applied shall be payable as negotiated between the Hospital and the responsible party. The account shall not be turned over to a Collection Agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the responsible party regarding payment.

Business Office Staff will work with the patient in order to obtain the documentation needed to complete the determination of eligibility for financial assistance. In the event that the applicant is unable to furnish the information, eligibility will be determined based on the information given and a signed statement from the applicant attesting to the correctness of the information.

In the event that hospital personnel can clearly establish that an indigent person qualifies for financial assistance, the account can be granted Charity Care without an application based on this determination.

THIRD PARTY PAYMENT SOURCE

Any and all insurance or third party payment sources must be exhausted prior to approval for financial assistance. All available benefit funds available on such coverage must be paid to the hospital. If there is insurance coverage, an explanation of benefits or insurance information should be attached to the application form.

Applicants will be screened to determine if they may qualify for Public Assistance (DSHS) using the Medicaid Eligibility Work Sheet furnished by DSHS. Any yes answers on the work sheet will signify that the applicant may receive DSHS benefits for their care received and will be required to apply before charity care will be approved. The applicant must complete the application process for Public Assistance (DSHS) and must present the DSHS Determination Notice to have the application for charity reprocessed. Staff is available to answer questions or to assist in this process.

EXCLUSIONS

Elective procedures and non-emergency services will be reviewed for charity consideration but are generally excluded from financial assistance through the Charity Care program.

Financial assistance and charity care shall be limited to appropriate hospital-based medical services as defined in WAC 246-453-010(7) and consist of Acute care and hospital outpatient services.

Charges for services provided by a physician, PA-C, or ARNP at Columbia Basin Hospital are excluded from Charity consideration. All services of Columbia Basin Family Medicine Clinic are also excluded from Charity consideration.

Accounts assigned to a collection agency and have a judgment granted through the court system are no longer eligible for charity consideration. A patient may apply for charity at any time prior to the account receiving a court judgment.

REVIEW PROCESS

Information, applications, and interviews for financial assistance will be handled by the Business Office. All requests for Charity Care Services will be processed within fourteen (14) business days of receipt of application and the applicant notified of the approval, denial, or need for more documentation. An application missing information needed for processing may be held up to 14 days, or such time as may reasonably be necessary, from the date the applicant is notified of the need for additional documentation in order to allow the applicant time to secure and present documentation in support of their application prior to receiving a determination. Missing information needed to determine eligibility may result in a denial of charity until the information is received and the application can be reprocessed. Once documentation is received, the Hospital will make the determination and notify the applicant within 14 days.

Completed applications with documentation will be reviewed by the Director of Business Services. He/she will approve or disapprove the applications based on the documentation attached. Then the applicant will be sent an Eligibility Determination notifying them of the approval or disapproval, the reason for the denial, and payment arrangements confirmed for any balance due. Also included in the notice are their appeal rights. The patient has 30 days from the date of determination to request an appeal. This request must be made in writing to the Director of Financial Services providing any additional information necessary to process the reconsideration. The Director of Financial services will reconsider the application and issue a determination to the patient and Business Office. A copy will be sent to the WA Dept. of Health as per State Regulation.

CONTINUING SERVICES

If a patient has qualified for financial assistance and continues to receive services for an extended period of time, the Hospital, at their discretion, may require the responsible party to submit a new application and documentation to ensure that they still qualify under the program.

CONFIDENTIALITY

Use and disclosure of any information contained in the request and processing of charity care services shall be subject to the Health Insurance Portability and Accountability Act Privacy Regulations and the hospital's Privacy Policies.

All information and documents pertaining to the charity care application will be kept with the application and shall be retained for five years.

REFUNDS:

Any personal payment made on an account later determined by approval of an application to have been eligible for Charity Care will be refunded to the patient within 30 days of that approval. The patient must have been eligible at the time the payment was received.

PUBLIC NOTIFICATION:

Signs indicating the availability of financial assistance through the Charity Care program are posted in the Business Office, Admitting, and Emergency Room areas. A Notice of Availability of Charity Care may be published in the legal notices of the local newspaper.

The hospital will include a written notice of the availability of financial assistance to patients at the time of their first billing or statement. This will include contact information for inquiries about the program or application process. Further written information shall be made available to any person who requests it and at each Admitting/registration area.

Our facility will make interpretive services available, as necessary, to provide assistance for non-English speaking patients in applying for charity assistance.

Any changes to this policy will be submitted to the WA Dept of Health for approval as required by state law before changes are put into effect.

Federal Poverty Guidelines

Family Size	100%	200%	300%
01	10400.	20800.	31200.
02	14000.	28000.	42000.
03	17600.	35200.	52800.
04	21200.	42400.	63600.
05	24800.	49600.	74400.
06	28400.	56800.	85200.
07	32000.	64000.	96000.
08	35600.	71200.	106800.

For family units with more than 8 members, add $3,600. for each additional member.

2008 Federal Poverty Guidelines: Gross Annual Income
Effective 012308

Charity Care Eligible Patients
Reduced Payment Schedule
Gross Annual Family Income

Family Size	-0-	75%	50%	25%	100%
01	Less than $10,400.	$10,401.-$13,832.	$13,833.-$17,263.	$17,264.-$20,799.	$20,800.
02	Less then $14,000.	$14,001.-$18,620.	$18,621.-$23,239.	$23,240.-$27,999.	$28,000.
03	Less than $17,600.	$17,601.-$23,408.	$23,409.-$29,215.	$29,216.-$35,199.	$35,200.
04	Less than $21,200.	$21,201.-$28,196.	$28,197.-$35,191.	$35,192.-$42,399.	$42,400.
05	Less than $24,800.	$24,801.-$32,984.	$32,985.-$41,167.	$41,168.-$49.599.	$49,600.
06	Less than $28,400.	$28,401.-$37,772.	$37,773.-$47,143.	$47,144.-$56,799.	$56,800.
07	Less than $32,000.	$32,001.-$42,560.	$42,561.-$53,119.	$53,120.-$63,999.	$64,000.
08	Less than $35,600.	$35,601.-$47,348.	$47,349.-$59,095.	$59,096.-$71,199.	$71,200.

Add $3,600. for each additional family member.

Based on 2008 Federal Poverty Guidelines
Effective 012308

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CENTER FOR HEALTH STATISTICS
HOSPITAL AND PATIENT DATA SYSTEMS
101 Israel Rd SE ● PO Box 47814 ● Olympia, Washington 98504-7814

January 23, 2008

TO: Chief Financial Officer

FROM: Richard Ordos, Office of Hospital & Patient Data

SUBJECT: 2008 FEDERAL POVERTY GUIDELINES

From the Federal Register dated January 23, 2008 are the 2008 Federal Poverty Guidelines for all states except Alaska and Hawaii and The District of Columbia:

Size of Family	Poverty Guideline
1	$10,400
2	14,000
3	17,600
4	21,200
5	24,800
6	28,400
7	32,000
8	35,600

For family units with more than 8 members, add $3,600 for each additional member.

These guidelines go into effect on the day they are published, January 23, 2008. Please contact me at (360) 236-4216, if you have any questions.

Grant County Public Hospital District #3
Notice of Availability of Financial Assistance

Grant County Public Hospital District #3 is committed to the provision of health care services to all persons in need of medical attention, regardless of ability to pay. Patients with no adequate means of paying for needed care – will be granted financial assistance in accordance with the District's charity care and non-discrimination policies.

Columbia Basin Hospital has available a limited amount of Financial Assistance to cover necessary or emergency medical treatment for persons eligible under charity care guidelines. It does not cover transportation costs, elective procedures, or services provided by medical personnel such as Physicians, PA-C, or ARNP.

Eligibility for Financial Assistance is determined by measuring personal and family income and assets against the established Federal Income Guidelines. If your income is below 300 percent of the federal poverty level and you have exhausted any other health care coverage available to you, then you should qualify for free or discounted medical services.

If you wish to apply for assistance, please contact our Business Office as soon as possible after receiving medical treatment. You will be asked to fill out a personal financial statement and furnish proof of your income. A denial of eligibility from Public Assistance (DSHS) may also be required. You may use W-2 forms, pay check stubs, income tax returns, etc. as part of your proof of income.

If you qualify, your medical bill may be reduced or written off. You will receive a written determination of eligibility within14 business days following receipt of your completed application, when accompanied by your financial statement and proof of income.

Please contact the Business Office with any questions you may have at 509-754-4631.

Medicaid Eligibility Work Sheet

This patient is...	Yes	No
Over the age of 65		
Disabled (unable to work for at least 90 days, receiving disability benefits, blind, has a condition that will lead to death, or permanent disability)		
Under the age of 19		
Pregnant		
Adult with minor children living in their home		

Send an application if the patient answers yes to any of the above questions; they may be eligible for Medicaid coverage.

An application is not necessary if all answers are no. The patient is not relatable to a Medicaid program.

If the patient still wants to apply for Medicaid coverage, they may submit an application.

Grant County Public Hospital District #3
Columbia Basin Hospital

Application for Financial Assistance through the Charity Care Program

Columbia Basin Hospital encourages you to apply for Financial Assistance if you are low income and need help paying hospital charges for inpatient or outpatient care. Charity Care may offer either free or reduced-price care based on your eligibility and income. If you have questions or need help completing this application, please call the Business Office at 509-754-4631 extension 124.

Patient's Name (s):_____ _____

Applicant Name: _____Spouse/Sig Other Name: _____

Address: _____

_____

Phone #: _____

Social Security #: _____Spouse Social Security #: _____

Employer name: _____Spouse Employer: _____

Position: _____Position: _____

# of years held: _____ # of years held: _____

List all persons living in your household:

Name:_____ Age:_____ Relationship:_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have Medical Insurance or other coverage?? _____

Name and address of Company:_____

Policy Number:_____

Please attach proof of your income to your application so that we can consider you for Financial Assistance. Examples of proof: Pay stubs from all employment for a one year period, W-2 withholding statements, last year's income tax return, letters from DSHS, Social Security, or unemployment noting your earnings, or written statements from your employers.

Gross Monthly Income

	Applicant	Spouse	Other family member
Wages from employment			
Child support or Alimony			
Unemployment payments			
Bonuses/Commissions			
Dividends/Interest			
Disability Income			
Social Security			
Retirement Benefits			
Earned Income Credit			
L&I benefits			
DSHS or Public Assistance			
Other Income:			
Total Gross Income			
Total Net Income			

List total family gross income for the past three months: $_____

Has your family had any seasonal or temporary increases or decreases in income? Or do you expect income to change in the next three months? Yes_____ No _____
Please describe: _____

Have you recently suffered severe financial hardship or personal loss (other medical expense, death of a loved one, loss of job or wages, loss of home, auto, or other property?
Yes _____ No _____ Please explain:_____
_____

Do the documents that you are including with this application show your current financial situation correctly? Yes_____ No _____ If no, why not? _____

_____

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Please note: The section below is required for catastrophic or sliding fee scale charity considerations only. If you meet the criteria for 100% poverty level charity this section is optional. Voluntary disclosure of this information may assist us in approving your application or further reducing the cost of your services through a sliding fee scale.

Monthly Housing Expenses

Rent/House Payments	
Homeowners Insurance	
Real Estate Taxes	
Utilities:	
Water	
Electric	
Cable/Satellite Dish	
Telephone/Cell Phone	
Total Monthly Housing Costs	

Available Assets

Description:	Cash Value
Checking/Savings Accounts	
Stocks/Bonds	
Life Insurance Net Cash Value	
Real Estate Owned	
Vested Interest in Retirement Fund	
Net Worth of Business owned	
Automobiles List make and year:	
Furniture and personal property	
Other Assets not listed above:	
Total Assets	

Liabilities

Creditors name, Address, Account #	Monthly pymt/Months left to pay	Unpaid Balance
Installment Debts and Charge Cards:	$	$
Current Medical Bills:		
Automobile Loans:		
Real Estate Loans		
Alimony, Child Support, Separate Maintenance pymts		
Other debts:		
Total Monthly Payments	$	

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All applicants must sign the application below and return it to the Business Office with any documentation requested to:

Columbia Basin Hospital
Attn: Business Office
200 Nat Washington Way
Ephrata, WA 98823

I understand that the information I am giving will be verified by Columbia Basin Hospital and reviewed by state and or/federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge. I have attached proof of my yearly income for consideration.

_____ _____

Signature of Applicant Date

Grant County Public Hospital District #3
Columbia Basin Hospital

Financial Assistance
Charity Care Program
Eligibility Determination

Your Financial Assistance Application has been processed and the following determination was made:

_____ The applicant is eligible for Financial Assistance. Your total charges in the amount of $_____ will be dismissed.

_____ The applicant is eligible for a partial reduction of their total charges.
$_____ will be dismissed as Financial Assistance.
$_____ will be still due from the applicant.
Please contact our Business Office to make arrangements for payment of the balance still owing.

_____ The applicant's request for Financial Assistance has been denied for the following reasons:

_____

_____

If your request for Financial Assistance thru the Charity Care Program is denied, you may, within 30 days of the receipt of this notice, file an appeal, or request for reconsideration of your application. This request must be made in writing to:

Director of Financial Services
Columbia Basin Hospital
200 Nat Washington Way
Ephrata, WA 98823

Please provide any additional information or verification needed in order to process your reconsideration. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to you and to the Wa. State Department of Health in accordance with State law.

_____ _____
Signature Date of Determination & notice to applicant

_____
Date Application Received

Type of Income verification:_____